

1  
 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

## CERTIFICATE OF DEATH

04622

4653

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Emmorton</u>		LENGTH OF STAY (in this place) <u>7 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Emmorton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Turner Road</u>				STREET ADDRESS (If rural give location) <u>1 Turner Road</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Joseph</u> (Middle) <u>Atwell</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>April 25, 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JANUARY 30, 1897</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Manufacturing</u>		11. BIRTHPLACE (State or foreign country) <u>Ceres, Blount County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William J. Atwell</u>				14. MOTHER'S MAIDEN NAME <u>Julie Ann Cornwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-10-6958</u>		17. INFORMANT & ADDRESS <u>Turner Road</u> <u>Nanie Bell Atwell Emmorton, R.D., Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CA PULMONUM</u>				<u>6 months?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>GASTRIC ULCER</u>				<u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTROPHY OF PROSTATE</u>				<u>2 months</u>			
19a. DATE OF OPERATION <u>March 20, 1958</u>		19b. MAJOR FINDINGS OF OPERATION <u>PROSTATECTOMY (URINARY RETENTION)</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 1957</u> , to <u>April 19, 1958</u> , that I last saw the deceased alive on <u>April 21, 1958</u> , and that death occurred at <u>1A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>D. A. Sandecki M.D.</u>				ADDRESS (Street, city, town, state) <u>BEL AIR, Md.</u> DATE SIGNED <u>April 25, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 27, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		LOCATION (City, town, or county) (State) <u>BEL AIR, Hartford Co., Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster</u> ADDRESS <u>Broadway And Williams St. BEL AIR, Maryland</u>			
DATE <u>APR 28 '58</u>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. PREVIOUS ILLNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. DATE OF REGISTRATION

16. PLACE OF REGISTRATION

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF CLERGYMAN

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CONSTABLE

23. SIGNATURE OF JURY

24. SIGNATURE OF GRAND JURY

25. SIGNATURE OF COURT

26. SIGNATURE OF STATE

27. SIGNATURE OF COUNTY

28. SIGNATURE OF CITY

29. SIGNATURE OF TOWNSHIP

30. SIGNATURE OF PARISH

31. SIGNATURE OF VILLAGE

32. SIGNATURE OF HAMLET

33. SIGNATURE OF CENSUS TRACT

34. SIGNATURE OF BLOCK

35. SIGNATURE OF HOUSEHOLD

36. SIGNATURE OF ROOM

37. SIGNATURE OF BED

38. SIGNATURE OF CHAIR

39. SIGNATURE OF TABLE

40. SIGNATURE OF CUPBOARD

41. SIGNATURE OF WARDROBE

42. SIGNATURE OF DRESSER

43. SIGNATURE OF BATH

44. SIGNATURE OF KITCHEN

45. SIGNATURE OF LIVING ROOM

46. SIGNATURE OF HALL

47. SIGNATURE OF PORCH

48. SIGNATURE OF PATIO

49. SIGNATURE OF GARAGE

50. SIGNATURE OF DRIVE

51. SIGNATURE OF FENCE

52. SIGNATURE OF GARDEN

53. SIGNATURE OF LAWN

54. SIGNATURE OF WALK

55. SIGNATURE OF PATH

56. SIGNATURE OF BRIDGE

57. SIGNATURE OF TOWER

58. SIGNATURE OF CHURCH

59. SIGNATURE OF SCHOOL

60. SIGNATURE OF STORE

61. SIGNATURE OF OFFICE

62. SIGNATURE OF FACTORY

63. SIGNATURE OF MILL

64. SIGNATURE OF BRIDGE

65. SIGNATURE OF TOWER

66. SIGNATURE OF CHURCH

67. SIGNATURE OF SCHOOL

68. SIGNATURE OF STORE

69. SIGNATURE OF OFFICE

70. SIGNATURE OF FACTORY

71. SIGNATURE OF MILL

72. SIGNATURE OF BRIDGE

73. SIGNATURE OF TOWER

74. SIGNATURE OF CHURCH

75. SIGNATURE OF SCHOOL

76. SIGNATURE OF STORE

77. SIGNATURE OF OFFICE

78. SIGNATURE OF FACTORY

79. SIGNATURE OF MILL

80. SIGNATURE OF BRIDGE

81. SIGNATURE OF TOWER

82. SIGNATURE OF CHURCH

83. SIGNATURE OF SCHOOL

84. SIGNATURE OF STORE

85. SIGNATURE OF OFFICE

86. SIGNATURE OF FACTORY

RECEIVED

BUREAU V. 8

APR 28 1930

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4636

## CERTIFICATE OF DEATH

04623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 weeks</u>		d. STREET ADDRESS <u>566 Green</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Elizabeth Bonell</u> First Middle Last		4. DATE OF DEATH <u>4/10/58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Siefert</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Plouffe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>John J. Francis Bonell</u> Address <u>566 Green</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nutritional Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/30th</u> , 19 <u>58</u> , to <u>April 10th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 10th</u> , 19 <u>58</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Foo, M.D.</u>		DATE SIGNED <u>April 12th</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>	
22a. BLIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Ever</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Rm. Howard Shaw, Md.</u>		ADDRESS <u>566 Green</u>	
24a. RECEIVED BY REGISTRAR <u>APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>One Carol</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

APR 16 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04624

Item 9, Film G228, 5/7/58 fey

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. David's</u>	c. LENGTH OF STAY IN 1b <u>Lifetime</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X A Berdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 7 - Box 10 Old Post Rd.</u>		d. STREET ADDRESS <u>Route #1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Bosley</u> Last <u>Bosley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-10</u>
9. AGE (In years last birthday) <u>47</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commissioner of Aldean Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Bosley</u>		14. MOTHER'S MAIDEN NAME <u>Berrettas French</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-4482</u>	
17. INFORMANT <u>Mrs. Albert Stothus, Philadelphia 31, Pa.</u>		Address <u>841 N. 20th St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Air</u> DATE SIGNED <u>4-20-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>St. James, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver J. Bullock - St. James, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

MEDICAL CERTIFICATION

2



FOR STATE  
HEALTH DEPT

STATE AND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*  
2. Age: *45*  
3. Sex: *Male*  
4. Race: *White*  
5. Date of Death: *April 28, 1958*  
6. Place of Death: *Home*  
7. Cause of Death: *Heart Disease*  
8. Manner of Death: *Natural*  
9. Signature of Examiner: *[Signature]*  
10. Date of Examination: *April 29, 1958*

BUREAU M. H.

APR 29 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

Reg. Dist. No.

4655

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>31</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lincoln Drive Avenue</b>				d. STREET ADDRESS <b>Lincoln Drive Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEANETTE</b> Middle <b>BROWN</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 February 1958</b>	
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b>		IF UNDER 24 HRS. Hours <b>10</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>** **</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry N. Brown</b>				14. MOTHER'S MAIDEN NAME <b>JoAnn McGee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>** **</b>		17. INFORMANT <b>Harry N. Brown, Lincoln Ave, Aberdeen</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia.</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Md.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/12/58</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Barron</b>		ADDRESS <b>Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

2071241XV3

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04626

## 4656 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural Box 2074</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Jones</u> First <u>A</u> Middle <u>Cox</u> Last		4. DATE OF DEATH <u>April 12</u> Month <u>12</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <del>MARRIED</del> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asst. Co. M.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Everett W. Cox</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fowler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>212-32-1199</u>	17. INFORMANT <u>Everett Cox</u> Address <u>Darlington Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>57</u> , to <u>April 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		FOREST HILL, Md. 4-13-58	
PHYSICIAN'S NAME (Type) <u>WILLARD P. HUDSON, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 16, 1958</u>	<u>Mt. Zion</u>	<u>Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bailey</u>		ADDRESS <u>Darlington, Md.</u>	24a. REC'D BY REGISTRAR <u>APR 18 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04627

## 4637 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVER DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BELAIR RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAMELA</b> Middle <b>Ann</b> Last <b>CROUSE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1956</b>
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edsel Brooks Crouse</b>	
14. MOTHER'S MAIDEN NAME <b>Ellen Louise Porter</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Edsel B. Crouse, Belair, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Mongolism</b> (c) <b>Congenital heart disease, cyanotic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/27</b> , 19 <b>58</b> , to <b>4/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/30</b> , 19 <b>58</b> , and that death occurred at <b>5:45</b> M., from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE <b>Theodore H. Kaiser</b> M.D. <b>APRIL 30, 1958</b> PHYSICIAN'S NAME (Type) <b>THEODORE H. KAISER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-2-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CONOWINGO BAPTIST</b>	22d. LOCATION (City, town, or county) (State) <b>RT. 222, CECIL CO., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins, Delta, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 3 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Harkins</b>



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet Road 104</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RD 2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Leo C. Davis</u>	4. DATE OF DEATH <u>April 7</u> 19 <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 28-1886</u>
9. AGE (in years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware (Ohio)</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Leo Charles Davis</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-10-2028</u>	
17. INFORMANT <u>Velma E Davis</u>		Address <u>Bel Air, RD 2nd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>4-7-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Apr 10-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wot Archer</u>		24a. REC'D BY REGISTRAR <u>Benson-Md</u> DATE <u>APR 11 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wot Archer</u>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEATH CERT.

MADE IN MARYLAND

CHIEF OF BUREAU

BUREAU V. 2

APR 11 1958

RECEIVED

## 4657 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pylesville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Pylesville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>			d. STREET ADDRESS <u>—</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE May DE ROLN</u>			4. DATE OF DEATH Month Day Year <u>April 20 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1892</u>		9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Tarrettsville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Thomas Gross</u>			14. MOTHER'S MAIDEN NAME <u>Jeanette Wetherill</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Mrs Wallace Wilson Pylesville Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 22 1958</u> , to <u>April 19 1958</u> , that I last saw the deceased alive on <u>April 19 1958</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Edward H. Hyson</u> M.D.			ADDRESS (Street, city or town, state) <u>Hawn Grove, Pa</u> DATE SIGNED <u>4/21/58</u>		
PHYSICIAN'S NAME (Type) <u>Edward W. Hyson</u>			<u>Hawn Grove, Pa</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Highland</u>	22d. LOCATION (City, town, or county) (State) <u>Street Harford Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martha E. Kutz</u> ADDRESS <u>Sanctusville Md</u>			24a. REC'D BY REGISTRAR DATE <u>APR 24 58</u>		
			24b. REGISTRAR'S SIGNATURE <u>Quail</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POST-MORTEM EXAMINATION	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF BURIAL	
19. NAME OF BURIAL PLACE		20. NAME OF MINISTER		21. NAME OF CHURCH	
22. NAME OF FUNERAL HOME		23. NAME OF CARRIAGE		24. NAME OF COFFIN	
25. NAME OF CLOTHING		26. NAME OF SHOE		27. NAME OF ACCESSORIES	
28. NAME OF JEWELRY		29. NAME OF OTHER PERSONS		30. NAME OF OTHER PERSONS	
31. NAME OF OTHER PERSONS		32. NAME OF OTHER PERSONS		33. NAME OF OTHER PERSONS	
34. NAME OF OTHER PERSONS		35. NAME OF OTHER PERSONS		36. NAME OF OTHER PERSONS	
37. NAME OF OTHER PERSONS		38. NAME OF OTHER PERSONS		39. NAME OF OTHER PERSONS	
40. NAME OF OTHER PERSONS		41. NAME OF OTHER PERSONS		42. NAME OF OTHER PERSONS	
43. NAME OF OTHER PERSONS		44. NAME OF OTHER PERSONS		45. NAME OF OTHER PERSONS	
46. NAME OF OTHER PERSONS		47. NAME OF OTHER PERSONS		48. NAME OF OTHER PERSONS	
49. NAME OF OTHER PERSONS		50. NAME OF OTHER PERSONS		51. NAME OF OTHER PERSONS	
52. NAME OF OTHER PERSONS		53. NAME OF OTHER PERSONS		54. NAME OF OTHER PERSONS	
55. NAME OF OTHER PERSONS		56. NAME OF OTHER PERSONS		57. NAME OF OTHER PERSONS	
58. NAME OF OTHER PERSONS		59. NAME OF OTHER PERSONS		60. NAME OF OTHER PERSONS	
61. NAME OF OTHER PERSONS		62. NAME OF OTHER PERSONS		63. NAME OF OTHER PERSONS	
64. NAME OF OTHER PERSONS		65. NAME OF OTHER PERSONS		66. NAME OF OTHER PERSONS	
67. NAME OF OTHER PERSONS		68. NAME OF OTHER PERSONS		69. NAME OF OTHER PERSONS	
70. NAME OF OTHER PERSONS		71. NAME OF OTHER PERSONS		72. NAME OF OTHER PERSONS	
73. NAME OF OTHER PERSONS		74. NAME OF OTHER PERSONS		75. NAME OF OTHER PERSONS	
76. NAME OF OTHER PERSONS		77. NAME OF OTHER PERSONS		78. NAME OF OTHER PERSONS	
79. NAME OF OTHER PERSONS		80. NAME OF OTHER PERSONS		81. NAME OF OTHER PERSONS	
82. NAME OF OTHER PERSONS		83. NAME OF OTHER PERSONS		84. NAME OF OTHER PERSONS	
85. NAME OF OTHER PERSONS		86. NAME OF OTHER PERSONS		87. NAME OF OTHER PERSONS	
88. NAME OF OTHER PERSONS		89. NAME OF OTHER PERSONS		90. NAME OF OTHER PERSONS	
91. NAME OF OTHER PERSONS		92. NAME OF OTHER PERSONS		93. NAME OF OTHER PERSONS	
94. NAME OF OTHER PERSONS		95. NAME OF OTHER PERSONS		96. NAME OF OTHER PERSONS	
97. NAME OF OTHER PERSONS		98. NAME OF OTHER PERSONS		99. NAME OF OTHER PERSONS	
100. NAME OF OTHER PERSONS		101. NAME OF OTHER PERSONS		102. NAME OF OTHER PERSONS	

BUREAU V. S.

APR 2, 1900

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

4639

04630

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harwick Grace</u>		LENGTH OF STAY (in this place) <u>1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS (If rural give location) <u>April 9, 1958</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Alice Douglas</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 11 1879</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Sharta M. C. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Gaston Reimer</u>				14. MOTHER'S MAIDEN NAME <u>Eane Crouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Jessie Morden</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>293X Fractured Rt Femur</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6h</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Severe Chronic Anemia</u>				<u>4y</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 58</u> , to <u>April 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 9</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. Bailey</u>				ADDRESS (Street, city, town, state) <u>Darlington Md</u>		DATE SIGNED <u>4/9/58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 12 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>		LOCATION (City, town, or county) (State) <u>Sharta M. C. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Darlington</u>	
DATE <u>APR 11 '58</u>							

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual English Name of Deceased

First

Middle

Last

Sex

Age

Birth

Color

Married

Single

Religion

Education

Occupation

Place of Birth

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Burial

Signature of Physician

Signature of Coroner

Signature of Registrar

Date

Time

Place

Signature of Deceased

Signature of Next of Kin

Signature of Witness

Signature of Minister

Signature of Chaplain

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Nurse

Signature of Doctor

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BUREAU V. E.

APR 11 1938

RECEIVED

INSTRUCTIONS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <b>4640</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>R D 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert M. Ellis</u> 4. DATE OF DEATH <u>April 4</u> 19 <u>58</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 4-1925</u> 9. AGE (in years last birthday) <u>32</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tenn Lines</u> 11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. FATHER'S NAME <u>Samuel Ellis</u> 14. MOTHER'S MAIDEN NAME <u>Alice Haynes</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>212-26-0958</u> 17. INFORMANT <u>Mrs Joan Ellis</u> Address <u>1212 N. Howard St. Baltimore, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>825x</u> DUE TO (c) <u>825x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>~</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto accident</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>15 Ave. 40 hr. Edgewood Harf. Md.</u> 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, Md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 8-1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u> 22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 8 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Edguch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04632

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HAVER DE GRACE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEM. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Murrell</u> Middle <u>EVANS</u> Last <u>EVANS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 6, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Fell Evans</u>		14. MOTHER'S MAIDEN NAME <u>Fredricka Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jessie E. Tolson, Haver de Grace Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V.D.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced Age</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> <u>5</u> <u>1958</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>58</u> , to <u>April 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>58</u> , and that death occurred at <u>11:15 AM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Don P. Bryant</u> M.D.		22. PHYSICIAN'S NAME (Type) <u>Ross Z. Pierpont</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-19-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Haver de Grace Md.</u>		24a. REC'D BY REGISTRAR <u>APR 21 1958</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED  
SEX  
AGE

RESIDENCE

PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

SEX  
AGE

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

NAME OF DECEASED  
SEX  
AGE

RESIDENCE  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

BUREAU V. S.

APR 21 1958

RECEIVED

## 4658 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural P.E.D. #2</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - ABERDEEN P.D. #2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ABERDEEN RD #2</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>WEBSTER</b> Middle <b>FINNEY</b> Last				4. DATE OF DEATH Month <b>APR</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 7 1869</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CANNING BROKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE JUNIUS FINNEY</b>				14. MOTHER'S MAIDEN NAME <b>LOUISA LYONS WEBSTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. James M. Finney</b> Address <b>Aberdeen P.E.D. #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>292.4 PNEUMONIA, HYPOSTATIC</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(Aplastic anemia)</b> DUE TO (c) <b>(Idiopathic)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>(1950)</b> , 19____, to <b>4-14-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-14-58</b> , 19____, and that death occurred at <b>11 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8 Low St Aberdeen Md.</b> DATE SIGNED <b>4-14-58</b>							
ACTUAL SIGNATURE <b>Peter P. Redman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Peter P. Redman, M.D.</b>				<b>Aberdeen Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>APR. 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Churchill Presbyterian Ch. Yd.</b>		22d. LOCATION (City, town, or county) (State) <b>Harford Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madigan Mitchell</b> ADDRESS <b>Harford Co. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE APR 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Lewis</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04634

## 4642 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 South <del>AM</del> BOND STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>HITCHCOCK</u> Middle <u>FOARD</u> Last				4. DATE OF DEATH <u>April</u> Month <u>29</u> , Day <u>1958</u> Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 5, 1880</u>			
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>					
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>William B. Hitchcock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Chenoworth</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Miss Ruth Foard</u> Address <u>200 S. Bond St. BEL AIR, Maryland</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>8 yls</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>June</u> , 19 <u>46</u> , to <u>April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>58</u> , and that death occurred at <u>4408</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>J. Ralph Horky</u> M.D.				ADDRESS (Street, city or town; state) <u>Churchville Md</u> DATE SIGNED <u>April 30</u>					
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky MD</u>				<u>Churchville Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Cross Roads, Harford Co., MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>West Broadway + Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			



4643 CERTIFICATE OF DEATH

04635

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DEGRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>	
c. LENGTH OF STAY IN 1b <u>2 days 18 hrs 24</u>		d. STREET ADDRESS <u>317 WILSON STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>B.</u> Last <u>HACKMAN</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7, 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SPRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. F. HACKMAN</u>		14. MOTHER'S MAIDEN NAME <u>LOUELLA MARLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-28-8173</u>	
17. INFORMANT <u>GRACE HACKMAN</u>		Address <u>HAURE DEGRACE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia left side -</u> DUE TO <u>Massive Cerebral Hemorrhage -</u> (c) <u>Malignant Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 26, 1958</u> to <u>April 29, 1958</u> , that I last saw the deceased alive on <u>April 29, 1958</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Walter Chid</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Harford, Md. 4/29/58</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 3, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OXFORD CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>OXFORD Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		24a. REC'D BY REGISTRAR <u>W. Leach</u>	
ADDRESS <u>Harford, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	
DATE <u>MAY 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4644

## CERTIFICATE OF DEATH

Reg. Dist. No.

04636

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>31</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>			1d. STREET ADDRESS <u>630 Colaine Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CONSTANCE</u> Middle <u>LOUISE</u> Last <u>HANDS</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/102</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Benj. E. Beavin Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Adam Clark Hands</u>			14. MOTHER'S MAIDEN NAME <u>Ira Celeste Goodwin</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-2313</u>		17. INFORMANT <u>Sister - Elsie May Pearson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Old Rheumatic Heart Disease</u> DUE TO (c) <u>years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis, Secondary</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 15th 1958</u> to <u>April 1st 1958</u> , that I last saw the deceased alive on <u>April 1st 1958</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>		DATE SIGNED <u>4/1/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		<u>Harre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4.5.58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - Balt.</u>		ADDRESS <u>17</u>		24a. REC'D BY REGISTRAR <u>APR 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Red Smith</u>

1980-1981

PR. 7 1958

RECEIVED

## 4645 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>154 BLOOMSBURY AVE.</b>				d. STREET ADDRESS <b>154 BLOOMSBURY AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>LURMAN</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 14 1890</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPERTY DEPT.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ROBERT C. JONES</b>				14. MOTHER'S MAIDEN NAME <b>LAURA ENGLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>212-07-2403</b>			
17. INFORMANT <b>WORLDWARI</b>				Address <b>Mrs. ETHEL C. JONES, Havre de Grace, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decomposition</b> <b>592 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Chronic Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. j. 19 p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3-2-58</b> to <b>4-22-58</b> , that I last saw the deceased alive on <b>4-22-58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>[Signature]</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 24, '58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison MITCHELL</b>				ADDRESS <b>Havre de Grace MD.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading.

BUREAU V. 3

APR 28 1958

RECEIVED

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04638

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

4659

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARCO L. Leonard</u>		4. DATE OF DEATH Month Day Year <u>April 29 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Oct. 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Leonard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jane Gullion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-5401</u>	
17. INFORMANT <u>Bertie B. Shinault</u>		Address <u>Box 74 Perryman, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-29-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarsing</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>Albrecht</u>		24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1. INTRODUCTION

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Received June 10, 1999

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>Jincy</b> Middle <b>A.</b> Last <b>Mc Millan</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>28,</b> Year <b>58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17, 1870</b>		9. AGE (In years last birthday) <b>87</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Fielder Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Rutherford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Howard B. Mc Millan, Forest Hill, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Hemorrhage</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Stomach</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <b>0. 11.</b> p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 4, 1958</b> to <b>April 28, 1958</b> , that I last saw the deceased alive on <b>April 27</b> , 19 <b>58</b> , and that death occurred at <b>3:00a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D. <b>Forest Hill, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt., Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Harford, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard R. McMillan Jr.</b>				ADDRESS <b>Abingdon, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. R. Smith</b>	

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18		CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH JAN 15 1890	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE JUN 15 1910	
9. NAME OF SPOUSE MARY E. HARRIS		10. PLACE OF MARRIAGE BALTIMORE, MARYLAND	
11. DATE OF DEATH JAN 15 1955		12. PLACE OF DEATH BALTIMORE, MARYLAND	
13. CAUSE OF DEATH Coronary Thrombosis		14. MEDICAL HISTORY Hypertension, Atherosclerosis	
15. SIGNATURE OF PHYSICIAN J. H. HARRIS		16. SIGNATURE OF DECEASED JAMES H. HARRIS	
17. SIGNATURE OF WITNESSES J. H. HARRIS, MARY E. HARRIS		18. SIGNATURE OF REGISTRAR J. H. HARRIS	

100-100

4646 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>4 hrs 35 Min</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial</b>		d. STREET ADDRESS <b>849 ONTARIO ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>NATHAN</b> Last <b>McVey</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 15, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH L. McVEY</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE JOLLINGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>217-03-0899</b>	
17. INFORMANT Address <b>HAVRE DE GRACE MD.</b>		Name <b>Mrs. Carrie E. BARNHARDT</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Cardiac Insufficiency - Pulmonary</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Edema - Chronic Cardiac - Right</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 8</b> , 1957, to <b>Apr 13</b> , 1958, that I last saw the deceased alive on <b>April 13</b> , 1958, and that death occurred at <b>2:05 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>C. L. Leure MD</b>		PHYSICIAN'S NAME (Type) <b>John A. Leure MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APR. 16, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAVRE DE GRACE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Madison Mitchell</b>		ADDRESS <b>HAVRE DE GRACE MD</b>	
24a. REC'D BY REGISTRAR <b>DATE APR 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

# STATE OF NEW YORK DEPARTMENT OF HEALTH - BALTHORE, 12

THE DAY OF

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

BUREAU V. 8

APR 15 1958

RECEIVED



4661

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryman</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryman</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Minnie</b> First <b>Gallup</b> Middle <b>Mitchell</b> Last		4. DATE OF DEATH <b>April</b> Month <b>12</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Sept. 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Gallup</b>		14. MOTHER'S MAIDEN NAME <b>Laura Grape</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>** **</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Parker Mitchell Jr. Perryman, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prostatic Uremia</b> <b>600.0</b> DUE TO <b>Chronic Pyelonephritis and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) <b>Arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January</b> , 19 <b>58</b> , to <b>April</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 7 - 58</b> , 19 <b>58</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 N. Phila. Blvd.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Andre Weiss</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Andre Weiss</b>		<b>Aberdeen, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Perryman, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Barruey</b>		ADDRESS <b>Aberdeen, Md.</b>	24a. REC'D BY REGISTRAR <b>APR 16 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Section 10

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		April 15, 1958		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation		Residence		Burial Place	
Heart Disease		Natural		Teacher		123 Main St.		St. Mary's Church	
Physician		Hospital		Funeral Home		Cemetery		Interment	
Dr. J. Smith		St. Mary's		Doe & Sons		Greenwood		Section 10	
Signature		Witness		Registrar		County		State	
J. Doe		J. Smith		J. Doe		Baltimore		Maryland	

BUREAU V. 2

APR 16 1958

RECEIVED

## CERTIFICATE OF DEATH

04642

Reg. Dist. No.

4662

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Martha E Price</u> First Middle Last		4. DATE OF DEATH <u>April 18</u> Month Day Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3/1879</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Amos</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>MD</u>	
17. INFORMANT <u>Harry E Price</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Mesenteric Thrombosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>46 hr</u> <u>45 hr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> 19 <u>55</u> , to <u>April 18</u> 19 <u>58</u> , that I last saw the deceased alive on <u>April 18</u> 19 <u>58</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u>		ADDRESS (Street, city or town, state) <u>Washington</u> DATE SIGNED <u>and 4/20/58</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 21/1958</u>	<u>Harford Co MD</u>	<u>Harford Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Washington</u>		24a. REC'D BY REGISTRAR <u>APR 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

21. FROM: LIAISON OFFICE OF HEALTH - BALTIMORE, MD

APR 23 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04643**

**FOR STATE HEALTH DEPT.**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Harford</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belt Air</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>125 Alice Ann St</b> e. STREET ADDRESS <b>125 Alice Ann St</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>32 Belt Air</b> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Elizabeth Ellen Robinson</b> First Middle Last <b>4. DATE OF DEATH</b> <b>April 18 1958</b> Month Day Year		<b>5. SEX</b> <b>F</b> <b>6. COLOR OR RACE</b> <b>C</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>July 1, 1911</b> <b>9. AGE</b> (in years last birthday) <b>46 yrs.</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Samuel Taylor</b> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Adeleine Jackson</b> <b>17. INFORMANT</b> <b>Virginia Taylor - Belt Air, Md.</b> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>260 X</b> <b>Diabetes Mellitus</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>			
<b>ACTUAL SIGNATURE</b> <b>Gerald E Palmer</b> <b>EXAMINER'S NAME (Type)</b> <b>Gerald E Palmer</b>		<b>CHIEF MEDICAL EXAMINER</b> <b>Belt Air</b> <b>ASSISTANT MEDICAL EXAMINER</b> <b>Md.</b> <b>DEPUTY MEDICAL EXAMINER</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>4-22-58</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Tabernacle Cemetery</b> <b>22d. LOCATION (City, town, or county)</b> <b>Belt Air, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>APR 23 '58</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Al. Lewis</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles J. Bullock - Shore de Grace, Md.</b> ADDRESS			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



BUREAU N. Y.

APR 23 1958

RECEIVED

Reg. Dist. No. 114644

1. PLACE OF DEATH a. COUNTY <b>Harford County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKS</b>		b. COUNTY <b>BALTIMORE</b>	
c. LENGTH OF STAY IN lb <b>5 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROCKS OF DEER CREEK NURSING HOME</b>		d. STREET ADDRESS <b>614 FAIRWAY DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HARRY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR 1-1883</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GASOLINE EQUIPMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Daniel Seward</b>		14. MOTHER'S MAIDEN NAME <b>Katherine - UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES ON 2</b>		16. SOCIAL SECURITY NO. <b>52-048-0700</b>	
17. INFORMANT <b>Mrs Jane S Gattens</b>		Address <b>32 Hamilton St Madison, N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 MALNUTRITION - EMACIATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PERNICIOUS ANEMIA, DIVERTICULITIS</b> DUE TO (c) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 MOS. OVER 8 YRS OVER 8 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ADENOCARCINOMA OF PROSTATE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 2</b> , 19 <b>57</b> , to <b>April 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>58</b> , and that death occurred at <b>Bel Air, Md</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>307 Hickory Bel Air, Md</b> DATE SIGNED <b>April 14, 1958</b> ACTUAL SIGNATURE <b>Philip W. Heuman</b> M.D. PHYSICIAN'S NAME (Type) <b>PHILIP W. HEUMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>APRIL 14/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Foster</b>		24a. REC'D BY REGISTRAR DATE <b>APR 15 '58</b>	
ADDRESS <b>Bel Air Md</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Smith</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>April 15, 1958</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		SIGNATURE OF REGISTRAR <i>W. H. Brown</i>	
DATE OF SIGNATURE <i>April 16, 1958</i>		DATE OF SIGNATURE <i>April 16, 1958</i>	

BUREAU V. S.

APR 15 1958

RECEIVED

## 4648 CERTIFICATE OF DEATH

04645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>23 1/2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>SHANNON</u> Last <u>SHANNON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboratory Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	9. AGE (In years last birthday) <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>JAMES SHANNON</u>		14. MOTHER'S MAIDEN NAME <u>EDNA (SHANNON) BRIDGES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary E. Shannon,</u>		Address <u>Joppa, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis of Coronary arteries</u> <u>420.1</u> DUE TO <u>with thrombosis (and myocardial infarction)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infarction</u> DUE TO (c) <u>Arteriosclerosis Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Small cerebral vascular thrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 13th, 1958</u> , to <u>April 5th, 1958</u> , that I last saw the deceased alive on <u>April 5th, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold Joppa</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>4/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. McKinnis</u>		ADDRESS <u>Abingdon, Md.,</u>	24a. REC'D BY REGISTRAR <u>APR 8 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Ed. Joppa</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1958

RECEIVED



4649

## CERTIFICATE OF DEATH

Reg. Dist. No.

04646

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 HRS. 35 MIN.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SIMPSON</u>		4. DATE OF DEATH Month Day Year <u>APRIL 28 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 28, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. SIMPSON</u>		14. MOTHER'S MAIDEN NAME <u>ETHEL WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHN W. SIMPSON</u>		Address <u>ABERDEEN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>Multiple Skull Fractures</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Concussion Atelectasis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/28</u> , 19 <u>58</u> , to <u>4/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George I. Stansbury</u> M.D.		ADDRESS (Street, city or town, state) <u>569 Revolution St. Havre de Grace, Md.</u>	
DATE SIGNED <u>4/30/58</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>--</u>	22d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harford Memorial Hospital</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071352XV5



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04647

Reg. Dist. No.

4650

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace POA</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>RD 1</u>		
3. NAME OF DECEASED (Type or print) <u>John E. Stansbury Jr.</u>			4. DATE OF DEATH <u>April 16 1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-39</u>	9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John E. Stansbury, Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Gertrude Nicholson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 57-60</u>			
16. SOCIAL SECURITY NO. <u>215-32-4554</u>		17. INFORMANT <u>Mrs. Gertrude J. Presbury, Harford de Grace Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture Skull</u> 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>4-16-58</u> Hour <u>7:30</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Earlton Rd.</u>	
20f. (City or town) <u>Harford de Grace</u>		20g. (County) (State) <u>Harford Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-17-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Methodist Cem.</u>	
22d. LOCATION (City, town, or county) <u>Gravelly Hill</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock</u>		ADDRESS <u>Harford de Grace Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Adams</u>					

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH BOARD

BUREAU V. S.

APR 21 1938

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4651

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	c. LENGTH OF STAY IN 1b <u>3 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1 Ellendale Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Roman</u> First <u>Turner</u> Middle Last		4. DATE OF DEATH <u>April 10</u> Month Day Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1 - 1885</u>
9. AGE (in years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM LABOR</u>	10. BIRTHPLACE (State or foreign country) <u>BEL AIR RURAL HARTFORD MD</u>
11. FATHER'S NAME <u>Richard Turner</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. MOTHER'S MAIDEN NAME <u>Ella Rigdon</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>	
15. SOCIAL SECURITY NO. <u>215-32-7203</u>		17. INFORMANT <u>LAWRENCE TURNER</u> Address <u>BEL AIR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-10-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>April 12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Forsyth Hill Hartford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. L. Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>APR 15 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS  
COUNTY OF [illegible]  
[illegible]

BUREAU V. S.

APR 15 1958

RECEIVED

**INSTRUCTIONS**

**1** The law requires that the death certificate be executed within 24 hours after death.

**2** The bottom copy may be retained by the hospital or attending physician.

**3** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**VS A15C 1-55 10M**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH**

04649

4664

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL BEL AIR</u>		LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL BEL AIR</u>		STREET ADDRESS (If rural give location) <u>ROCK SPRING AVE.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROCK SPRING AVE.</u>				STREET ADDRESS <u>ROCK SPRING AVE.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Virginia LEAH VALOS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 19, 1958</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>March 10, 1903</u>		<b>9. AGE last birthday</b> <u>55</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOUSEWIFE</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Parkersburg, West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George S. Smith</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alvina Mickel</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>232-54-0324</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Jack A. Valos Rock Spring Ave, Bel Air, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>443X UREMIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CONGESTIVE HEART FAILURE</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>HYPERTENSION, ARTERIOSCLEROTIC</u>						<u>10 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>July 4, 1957</u> to <u>April 19, 1958</u> , that I last saw the deceased alive on <u>April 17, 1958</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>A. I. Sandeeki M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>15 Courtland, BEL AIR, Md</u>			
<b>DATE</b> <u>APR 22 1958</u>				<b>DATE SIGNED</b> <u>4.19.58</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>April 22, 1958</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>EVERGREEN Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Parkersburg West Virginia</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Joseph W. Fater</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>West Broadway BEL AIR, Maryland</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

APR 22 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4665 CERTIFICATE OF DEATH

04650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Darlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Lena</u> First <u>Hagner</u> Middle Last		4. DATE OF DEATH <u>April 30</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15, 1917</u> yrs. Months Days Min.
9. AGE (In years last birthday) <u>40</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wilkes Corp. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Murdock Billings</u>		14. MOTHER'S MAIDEN NAME <u>Myella Caudill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-342353</u>	
17. INFORMANT <u>Darlington</u> Address <u>Hagner</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>19</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/1</u> 19 <u>57</u> , to <u>April 30</u> 19 <u>58</u> , that I last saw the deceased alive on <u>April 15</u> 19 <u>58</u> , and that death occurred at <u>11:58</u> P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D.		<u>Darlington Md</u> <u>5/2/58</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Franklin Ave</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u> ADDRESS <u>Darlington Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04651

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Somerset</u> 75x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	c. LENGTH OF STAY IN 1b <u>none</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 40</u>		d. STREET ADDRESS <u>363 W. Main</u>	
3. NAME OF DECEASED (Type or print) <u>William Jay Walker</u> First Middle Last		4. DATE OF DEATH <u>April 18</u> Month Day Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27th 1908</u> 29 yrs.
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dealer Self emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Walker</u>		14. MOTHER'S MAIDEN NAME <u>Erena Adbrook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-76-5747</u>	
17. INFORMANT <u>Johnson and Son Funeral Home</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>4-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Berlin</u>	22d. LOCATION (City, town, or county) (State) <u>200 F. Berlin Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Sarring</u> ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH OFFICE

BUREAU V. 2.

APR 22 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4667

CERTIFICATE OF DEATH

04652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>		c. LENGTH OF STAY IN 1b <b>x</b> <b>Aberdeen (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. 3 Box 302</b>		d. STREET ADDRESS <b>R.D. 3 Box 302</b>	
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>Alberta</b> Last <b>Warfield</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 March 1882</b>
9. AGE (In years lost birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Oliva Stansbury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>*** **</b>	
17. INFORMANT <b>Robert E. Warfield</b>		Address <b>R.D. 3 Aberdeen, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Hypertensive Cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/16</b> , 19 <b>58</b> , to <b>4/4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/4</b> , 19 <b>58</b> , and that death occurred at <b>1:00 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>569 Revolution St.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>George T. Stansbury</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>George T. Stansbury M.D.</b>		<b>Havre de Grece, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/7/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union M.E. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen R.D. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		ADDRESS <b>Aberdeen, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED: **Benjamin Johnson**  
 SEX: **Male**  
 AGE: **30**  
 DATE OF BIRTH: **March 29, 1928**  
 PLACE OF BIRTH: **Harford, Maryland**  
 OCCUPATION: **None**  
 CAUSE OF DEATH: **Heart Disease**  
 PLACE OF DEATH: **Harford, Maryland**  
 DATE OF DEATH: **April 9, 1958**  
 SIGNATURE OF PHYSICIAN: **Robert J. Harfield, M.D.**  
 SIGNATURE OF REGISTRAR: **Oliver E. Johnson**

**BUREAU V. 5**

APR 9 1958

**RECEIVED**

UNION ... Maryland

APPROVED, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04653

Reg. Dist. No.

4668

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b <u>none</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Office Dr F O Hodous</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter J.</u>		4. DATE OF DEATH <u>April 4</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1935</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter H. Whitt</u>		14. MOTHER'S MAIDEN NAME <u>Leola Lawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-32-8621</u>	
17. INFORMANT <u>Wanda V. Whitt,</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound</u> 814X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>814X</u> (a), stating the underlying cause lost. (c) <u>814X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>814X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motorcycle accident, cycle - object type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4-4</u> 19 <u>58</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 7</u>	20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerold C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air md</u> DATE SIGNED <u>4-5-58</u>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold R. McGraw Jr</u>		ADDRESS <u>Abingdon, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HOSPITAL



BUREAU V. 1

APR 9 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>House of Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Pylesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Jesse H. Woods</u>		4. DATE OF DEATH <u>April 21 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 1927</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>FEGG MILL</u>	
13. FATHER'S NAME <u>POE WOODS</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE THARP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>178-24-9122</u>	
17. INFORMANT <u>Mrs. Rae Woods</u>		Address <u>Fawn Lane, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>4-4-58</u> Hour <u>1:30</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Suspect House</u>		20f. (City or town) <u>Covington</u> (County) <u>Harford</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD.</u>		DATE SIGNED <u>4-21-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FELLOWSHIP CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PYLESVILLE, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Chubb</u>		ADDRESS <u>Stewartstown, Pa.</u>	
24a. REC'D BY REGISTRAR <u>APR 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH OFFICE



OFFICE OF THE COMMISSIONER

BUREAU V. E.

APR 23 1938

RECEIVED